Manipulation Under Anesthesia

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Instructions for Use

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Application

UnitedHealthcare Commercial

This Medical Policy applies to all UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado.

Coverage Rationale

Manipulation under anesthesia (MUA) is proven and medically necessary for:
- Knee joint for Arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Shoulder joint for adhesive capsulitis (frozen shoulder) when certain criteria are met. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Manipulation Under Anesthesia, Shoulder.

  Click here to view the InterQual® criteria.

MUA is unproven and not medically necessary for all other conditions (whether for single or serial manipulations) including but not limited to the following, due to insufficient evidence of efficacy:
- Ankle
- Finger
- Hip joint or adhesive capsulitis of the hip
- Knee joint - any condition other than for Arthrofibrosis following total knee arthroplasty, knee surgery, or fracture
- Pelvis
- Spine
- Temporomandibular joint (TMJ)
- Toe
- Wrist

This policy does not apply to the following:

- Manipulation of the finger on the day following the injection of collagenase clostridium histolyticum (Xiaflex®) to treat Dupuytren's contracture
- Closed reduction of a fracture or joint dislocation unless specified
- Elbow joint for Arthrofibrosis following elbow surgery or fracture

Definitions

Arthrofibrosis: A complication of injury or trauma where an excessive scar tissue response leads to painful restriction of joint motion, with scar tissue forming within the joint and surrounding soft tissue spaces and persisting despite rehabilitation exercises and stretches. (International Pain Foundation)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
22505	Manipulation of spine requiring anesthesia, any region
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
25259	Manipulation, wrist, under anesthesia
26340	Manipulation, finger joint, under anesthesia, each joint
27198	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (i.e., general anesthesia, moderate sedation, spinal/epidural)
27275	Manipulation, hip joint, requiring general anesthesia
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
27860	Manipulation of ankle under general anesthesia (includes application of traction or another fixation apparatus)

HCPCS Code	Description
D7830	Manipulation under anesthesia

Diagnosis Code	Description
Knee	
M24.661	Ankylosis, right knee
M24.662	Ankylosis, left knee
M24.669	Ankylosis, unspecified knee
Shoulder	
M24.611	Ankylosis, right shoulder

Diagnosis Code	Description
Shoulder	
M24.612	Ankylosis, left shoulder
M24.619	Ankylosis, unspecified shoulder
M75.00	Adhesive capsulitis of unspecified shoulder
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder

Description of Services

Manipulation under anesthesia (MUA) is a non-invasive procedure which combines manual manipulation of a joint or the spine with an anesthetic. Individuals who are unable to tolerate manual procedures due to pain, spasm, muscle contractures, or guarding may benefit from the use of an anesthetic agent prior to manipulation. Anesthetics may include intravenous general anesthesia or mild sedation, injection of an anesthetic to the affected area, oral medication such as muscle relaxants, inhaled anesthetics, or any other type of anesthetic medication therapy. Because the patient's protective reflex mechanism is, absent under anesthesia, manipulation using a combination of specific short lever manipulations, passive stretches, and specific articular and postural kinesthetic maneuvers to break up fibrous adhesions and scar tissue around the joint and surrounding tissue is made less difficult. Manipulation procedures can be performed under either: general anesthesia, mild sedation, or local injection of an anesthetic agent to the affected area (Reid, 2002).

Spinal manipulation under anesthesia (SMUA) consists of spinal manipulation and stretching procedures performed on the patient after an anesthetic is administered (e.g., mild sedation, general anesthesia). This is typically performed by chiropractors, osteopathic physicians, and orthopedic physicians along with an anesthesiologist. Theoretically, SMUA is thought to stretch the joint capsules to break up adhesions within the spinal column to allow for greater mobility and reduced back pain; however, this has not been proven to be safe or effective in the peer-reviewed literature.

Clinical Evidence

Knee

Haffar et al. (2022) conducted a systematic review comparing outcomes of MUA, arthroscopic lysis of adhesions (aLOA), and revision total knee arthroplasty (rTKA) for treatment of arthrofibrosis and stiffness after TKA. The primary endpoint was patient-reported outcome measures (PROMs) and secondary outcomes were range of motion (ROM) and percentage of patients who pursued further treatment for stiffness. There were 40 studies included in the review 17 of which applied to MUA. For MUA, the authors noted an average ROM increase of 20.97° post-operatively. The authors also noted that all studies that reported pre-operative and post-operative Knee Society (KSS) clinical and functional scores showed improvement at final follow-up following MUA. Additionally, only 17% of MUA patients required further care. Limitations included poor quality of evidence for the majority of studies included in this review.

Lim et al (2021) conducted a study that evaluated the effect of manipulation under anesthesia (MUA) outcomes using clinical outcomes regarding range of motion (ROM) and patient satisfaction following total knee arthroplasty (TKA). This is a retrospective study of 97 patients post bilateral primary TKA. The study shows postoperative flexion was significantly greater in the MUA group at the 6 months follow up, and at the 2 year follow up. Additionally, at the 12 months follow up patient satisfaction scores were substantially higher in the MUA group. The authors concluded MUA improves clinical outcomes such as ROM and patient satisfaction after primary TKA.

Randsborg et al. (2020, included in Haffar (2022) systematic review above) evaluated a case series of participants that experienced MUA for knee stiffness following a TKA. 24 patients met the inclusion criteria; MUA was performed following a TKA, along with 2-3 days of continuous passive motion therapy and enhanced physiotherapy with home exercises upon discharge. The authors concluded the study supported previous findings that MUA for knee joint stiffness following a TKA improves ROM both in the short and long term. Limitations included small sample size, no comparison to a comparison group undergoing a different treatment or no treatment and retrospective design.

Gu et al. (2018) conducted a systematic review of the efficacy of MUA for stiffness following TKA. Twenty-two studies (1488 patients) reported on ROM after MUA, and 4 studies (81 patients) reported ROM after repeat MUA. However, none of the studies appeared to include a comparison group without MUA, limiting the conclusions that can be drawn. All studies reported pre-MUA motion of less than 90°, while mean ROM at last follow-up exceeded 90° in all studies except 2. For studies reporting ROM improvement following repeat MUA, the mean pre-manipulation ROM was 80° and the mean post-manipulation ROM was 100.6°. The authors concluded that MUA remains an efficacious, minimally invasive treatment option for post-operative stiffness following TKA and provides clinically significant improvement in ROM for most patients, with the best outcomes occurring in patients treated within 12 weeks post-operatively. The quality of studies, variability of inclusion criteria and methods for reporting the data, the lack of comparison groups and variability in the physical therapy (PT) regimens were just a few limitations identified in this systematic review. Additional research is expected to provide clarity regarding timing of MUA interventions and post-procedure PT protocol.

Fabricant et al. (2018) evaluated (not included in the Gu, et al. systematic review) in a case series ninety patients aged 18 years and younger who underwent lysis of adhesions (LOA) and MUA at an urban tertiary care hospital following prior knee surgery. The primary purpose of this study was to report improvements in ROM following LOA/MUA in children and adolescents with knee arthrofibrosis, and, secondarily, to evaluate for any effect of preoperative dynamic splinting on ROM outcomes. Demographic, clinical, ROM, and revision data were all compiled. Mean time from index surgery to LOA/MUA was 6.0 ±4.4 months, and follow-up was 42 ±56 months. The authors found 62% of the participants had full ROM at follow up, and 25% had functional ROM. It was concluded that LOA/MUA for children with arthrofibrosis in the knees results in significant improvements in ROM with 90% revision-free success. Limitations of the study included lack of comparison group and small sample size.

A matched case control study (excluded from the Gu, et al. systematic review, but included in the Haffar et al. (2022) systematic review) was conducted by Pierce et al. (2017) to assess the incidence of revision TKA among patients who underwent or did not undergo MUA after initial TKA. A prospectively collected database of two high-volume institutions was assessed for patients who required a single MUA following TKA between 2005 and 2011. The study included138 knees with a mean 8.5-year follow-up post-MUA. This was compared with a matched cohort (1:1) who underwent TKA during the same time but did not require an MUA. Incidence of revision surgery and clinical outcomes were compared between the two cohorts. Nine knees underwent revision in the MUA cohort, and seven revisions were performed in the matched cohort. The mean Knee Society Score (KSS) and clinical scores were similar between the two cohorts. The authors concluded that undergoing an MUA was not associated with an increased risk of revision TKA. However, patients requiring MUA after an initial TKA may have been different from those not requiring MUA, limiting the conclusions that can be derived from this study.

Sassoon et al. (2015) performed a retrospective review on a case series of 22 patients (not included in the Gu, et al. systematic review) to evaluate whether closed manipulations performed under anesthesia were an effective means to treat posttraumatic knee arthrofibrosis. Injuries included fractures of the femur, tibia, and patella as well as ligamentous injuries and traumatic arthrotomies. The mean time from treatment to manipulation was 90 days and a mean follow-up after manipulation was 7 months. The authors found improvement of ROM for the knee was the primary outcome. It was concluded MUA is a safe and effective method to increase knee ROM in the setting of posttraumatic arthrofibrosis. Limitations of the study included lack of comparison group and small sample size.

Fitzsimmons et al. (2010) conducted a systematic review to outcomes between studies that used either MUA arthroscopy with or without MUA, or open arthrolysis for knee stiffness following TKA. The review evaluated 23 studies. MUA alone resulted in a mean gain in knee motion of 30 to 47 degrees. Range of motion in the arthroscopy group increased between 18.5 to 60 degrees. The open arthrolysis group had less gain in range of motion with gains between 19 and 31 degrees. The authors concluded that both MUA and arthroscopy provide similar gains in range of motion for patients with knee stiffness following total knee arthroplasty. Open arthrolysis had less favorable results. While this review compared outcome between treatments, all comparisons were indirect, as each included study used one of the approaches only.

Spine

The available evidence for manipulation under anesthesia for the spine is insufficient to consider the procedure proven to be effective and safe.

Taber et al. (2014) performed a retrospective chart review of 18 cases treated MUA for lumbopelvic pain at an outpatient ambulatory surgical center. Patients with pre- and postintervention Oswestry Low Back Pain Disability Index (ODI) scores were

included along with patients having lumbopelvic and hip complaints. ODI scores were assessed within one week prior to MUA and again two weeks after the procedure. The participants underwent two to four chiropractic MUA procedures over the course of a week per the National Academy of Manipulation Under Anesthesia physicians' protocols. Preprocedural ODI scores ranged from 38 to 76; postprocedural scores range from 0 to 66. For each patient, the ODI scores were lower with average decrease of 20.6. The authors identified sixteen of the eighteen patients experienced meaningful improvement of their pain. Limitations of the study included small study size, no control group, potential bias, and insufficient data on long-term safety. The authors suggested future large scale, carefully controlled prospective studies be performed.

Methodological limitations of studies reported in a narrative review (DiGiorgi, 2013) of the literature investigating spinal manipulation under anesthesia (SMUA) concluded that, "the evidence of treatment efficacy [SMUA] remains limited, with published studies that are generally weak in their methodological quality and consistently varied across multiple domains which do not permit comparative analysis toward generalization." Similarly, a review (Dagenais, et al, 2008) of medication-assisted manipulation for patients having chronic low back pain reported, "there is insufficient research to guide clinicians, policy makers, and especially patients' decision whether to consider this treatment [spinal medication-assisted manipulation] approach." MUA for low back pain has been used for many years however there is insufficient evidence in the published literature to support the long-term safety and efficacy of its use.

In a prospective study of 68 patients with chronic low-back pain, Kohlbeck et al. (2005) compared changes in pain and disability for chronic low-back pain patients receiving treatment with medication-assisted manipulation (MAM) to patients receiving spinal manipulation only. All patients received an initial 4- to 6-week trial of spinal manipulation therapy (SMT), after which 42 patients received supplemental intervention with MAM and the remaining 26 patients continued with SMT. Low back pain and disability measures favored the MAM group over the SMT-only group at 3 months. The authors concluded that medication-assisted manipulation appears to offer some patients increased improvement in low back pain and disability; however, the study is limited by lack of randomization, small sample size, insufficient data on long-term safety, and significant baseline differences between groups for the primary outcome variable (pain/disability scale).

In a prospective controlled study by Palmieri and Smoyak (2002), 87 patients who received either SMUA or traditional chiropractic treatment for low back pain were evaluated. The participants were assigned to one of two groups: 38 to an intervention group who received SMUA and 49 patients to a nonintervention group who received traditional chiropractic treatment. Patients were followed for 4 weeks. Self-reported outcomes, including back pain severity and functional status, were used to evaluate changes. The SMUA group had an average decrease of 50% in the Numeric Pain Scale scores while the nonintervention group had a 26% decrease. The SMUA group had an average decrease of 51% in the Roland-Morris Questionnaire scores while the nonintervention group had a 38% decrease. The authors concluded that while there was greater improvement in the intervention group, additional studies are needed to evaluate the safety and effectiveness of MUA. This study has a high risk of bias due to the methods used to select subjects, lack of assessor blinding, failure to isolate the effects of the active intervention, and interpretation of outcomes. Subjects were selected largely based upon 2 criteria: meeting NAMUAP eligibility requirements and having insurance coverage for SMUA. This led to significant baseline heterogeneities between intervention and control groups. Sample size (N = 87; SMUA group = 38; SMT group = 49) did not reach anticipated number of participants. The attempt to measure the difference in treatment effect between SMUA and SMT was confounded by the addition of a specific exercise protocol for the SMUA group vs. an undefined "home exercise" program for the SMT group. Follow-up period was limited and therefore insufficient data on long-term safety are available. Problems with obtaining timely follow-up data were reported. The use of a percentile difference in outcome scores between groups does not consider if each outcome of interest exhibited a clinically meaningful difference between each group. In fact, there were no statistical or clinically meaningful differences between groups. There was a difference of 1.52 points on the NRS at initial follow-up and 1.32 points difference at final follow-up (the minimal clinically important change has been widely reported as 2 points). The difference at initial follow-up for the RMDQ was 2.2 points and at final follow-up was 1 point (as noted in the study, a 4-point difference is necessary for it to be clinically meaningful).

Temporomandibular Joint (TMJ)

TMJ may spontaneously resolve or reoccur or respond to warm compresses, non-steroidal anti-inflammatory drugs (NSAIDs) splint therapy or physical therapy. However, the available evidence for manipulation under anesthesia for temporomandibular joint syndrome is limited to small, uncontrolled studies with limited follow-up.

Foster et al. (2000) studied 55 patients receiving manipulation under general anesthesia of the temporomandibular joint to determine the success rate of MUA effectiveness to reduce the number of patients being referred for invasive surgery. Of the

55 patients participating in this study, 15 improved, 15 did not, 6 showed partial improvement and 19 were not treated. The median pre-treatment opening was 20mm (range 13-27). Among those who improved after manipulation, the median opening after treatment was 38mm (range 35-56). The authors concluded that MUA may help some patients; however, some of those who improved experienced a return of TMJ clicking but not of joint or muscle tenderness. Furthermore, this study is limited by lack of comparison group.

Toe

The available evidence for manipulation under anesthesia for a toe is insufficient to consider the procedure proven to be effective and safe.

Ajwani et al. (2018) assessed 35 patients that had undergone first metatarsophalangeal joint (MTPJ) surgery to determine the effectiveness of MUA and steroid injection to treat joint stiffness. Documentation of ROM measurements and radiographs were reviewed. A mixture of depomedrone and bupivacaine were used for the steroid injection. Following MUA, the participants were given the Manchester–Oxford foot questionnaire (MOXFQ) to complete for assessment of their level of joint pain. The mean pre-manipulation total range of movement at the first MTPJ was 25° (range 5–100), immediate post-manipulation ROM was 70° (10–180), and final follow-up ROM was 50° (10–90). The average post-operative MOXFQ score was 25.2 (out of 52). The authors concluded joint ROM significantly improved after manipulation by a mean of 44.7 degrees. Limitations included small sample size, retrospective in nature and lack of randomization with no control or comparative groups.

Feuerstein et al. (2016) performed a medical records review study (n-38) to investigate the intermediate and long-term outcomes of first MTP joint manipulation for arthrofibrosis that developed, specifically, as a complication of hallux valgus surgery. Medical records were reviewed at the Weil Foot and Ankle Institute, IL to identify those patients who had undergone first MTP joint manipulation under anesthesia. Before the patient's visit, the medical records were reviewed to assess the course and timing of the procedures, visual analog scale (VAS) score before manipulation and ROM of the first MTP joint after hallux valgus correction and before manipulation and first MTP joint ROM immediately after manipulation. Manipulation procedures occurred at a mean 1.2 years from the date of the initial hallux valgus correction. The research visits occurred at a mean 6.5 years after the first MTP joint manipulation. Before manipulation, the patients had a mean VAS score of 6.5. At the research visit, the mean VAS score was 2.3. The authors concluded that joint motion was significantly improved in the direction of dorsiflexion and plantar flexion from before manipulation to both immediately after manipulation and at the final follow-up visit. They stated that the study demonstrated that joint manipulation under anesthesia could be a useful treatment modality to increase mobility and decrease pain in the patient. The limitations of the study include the lack of randomization, lack of a control or comparison group, and potential selection bias.

Other

Clinical evidence was not identified regarding manipulation under anesthesia for treating any condition (for single or serial manipulations) related to the following:

- Ankle
- Finger
- Hip
- Pelvis
- Wrist

Clinical Practice Guidelines

American College of Occupational and Environmental Medicine (ACOEM)

In a recommendation regarding MUA, the ACOEM (2020) concludes MUA, and medication-assisted spinal manipulation (MASM) are not recommended due to lack of quality studies that solely evaluate MUA or MASM for treatment of acute, subacute, or chronic lower back pain (Hegmann et al., 2020).

In a recommendation regarding MUA, the ACOEM (2016) has concluded that MUA and medication-assisted spinal manipulations are not recommended due to insufficient evidence of safety and effectiveness for acute, subacute, and chronic cervicothoracic pain.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Manipulation is a procedure and therefore not subject to FDA regulation.

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Policy History/Revision Information

Date	Summary of Changes
10/01/2023	**Application** ***Individual Exchange Plans*** • Removed language indicating this Medical Policy does not apply to Individual Exchange benefit plans in the states of Massachusetts, Nevada, and New York **Supporting Information** • Archived previous policy version 2023T0515V

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines, as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.